June 30, 2010

Testimony to the National Commission for Fiscal Responsibility and Reform

I am Dr. Margaret Flowers and I am here today on behalf of Physicians for a National Health Program, the leading physician research, education and advocacy organization in support of a truly universal single payer health system in the US. I will speak specifically about the contribution of health care costs to our national deficit and the evidence-based remedy to control these costs.

When compared to health care in other advanced nations, the United States excels in only one area – the amount of money spent per capita per year. Despite our high spending, the US leaves a third of the population either uncovered or underinsured and thus vulnerable to financial ruin. Medical debt is the leading cause of bankruptcy and foreclosure in our nation despite the fact that most families declaring medical bankruptcy had insurance when they began incurring such debt. Our health outcomes are relatively poor, placing us 37$^{th}$ in the world, and we rank the highest in preventable deaths, over 100,000 preventable deaths per year, when compared to other advanced nations. It is clear that we are getting poor value in return for our health care dollar.

Health care costs, which are rising 2.5% faster than our GDP, are a leading driver of our financial deficit. In fact, if our health care costs were comparable to those in other advanced nations, which provide nearly universal health care with better outcomes, we would currently experience a budget surplus. The recent health legislation, misleadingly titled the Patient Protection and Affordable Care Act (PPACA), lacks proven cost controls and is predicted to cause US health care costs to rise faster than if there had been no reform at all (CMS,April, 2010) despite continuing to leave tens of millions out.

Given the impact of health care costs, members of this commission may attempt to decrease the deficit by cutting our public health insurance programs, Medicaid and Medicare; however, doing this would be a mistake because it would increase poverty, worsen health outcomes and increase costs. Since its enactment nearly 45 years ago, Medicare has lowered poverty among the elderly by over 60%. Studies show that health disparities in the US start decreasing when our population reaches the age of 65. And the cost of health care per beneficiary is rising more slowly for those on Medicare than for those with private health insurance.

Medicaid and Medicare have not caused our rising health care costs but are victims of our fragmented and failed market-based model of health care financing. Shifting the cost of health

care from the taxpayer to the patient will not magically make these health care costs disappear or become sustainable.

The solution to our economic crisis is to jettison the costly failed market model of health care and adopt a publicly financed and independently delivered national improved Medicare for All. This is commonly known as “single payer.” A national improved Medicare for All system has myriad benefits:

- Administrative savings of approximately $400 billion per year which is enough to provide comprehensive high quality health care to all who are uninsured and underinsured.
- Ability to negotiate for pharmaceutical prices as a monopsony which would lower costs by one half to two thirds and bring our prices in line with those of other advanced nations.
- Inherent cost controls of global budgeting for health facilities, negotiated fees, bulk purchasing and rational, rather than profit-driven, allocation of capital expenditures and health resources.
- Ability to identify outliers and develop quality improvement tools.
- Eliminate the burden of rising employee health care costs on businesses.
- Enhance the competitiveness of US products in international markets.
- Liberate our population to pursue advanced education or entrepreneurial enterprises.
- Allow older workers to retire which would increase job opportunities for our younger workers.
- Stimulate the economy because families would have more money for discretionary spending.
- Improve the health, and therefore the productivity, of our workforce.
- Eliminate bankruptcy and foreclosure due to medical debt.
- Eliminate the spend-down required for those who need long-term care funded by Medicaid.

- Provide true health security to our population so that nobody has to choose between necessary medical care and other necessities such as housing, food, education and clothing.

Given these multiple economic benefits, and I have not begun to describe the ways in which national improved Medicare for All would improve patient choice and quality of health care, it is no surprise that the single payer approach is supported by the majority of those in the US and the majority of American physicians. This was evident once again last Saturday in the town meetings sponsored by America Speaks when participants across the nation demanded single payer as an option to solving the health care crisis and 71% voted not to cut Medicaid and Medicare.

Private health insurance is rapidly becoming a thing of the past. There is a steady trend in fewer people being enrolled in employee-sponsored health plans. This is expected to increase under PPACA as businesses have an incentive to drop insurance benefits and pay the lower cost penalty. There is a steady trend in people choosing high deductible plans which leave them financially vulnerable in their time of need. As people enter the individual market, those with health conditions will find it difficult to afford adequate insurance. The trends for those who are uninsured and underinsured will continue upward. Under PPACA, billions of public dollars will be used to subsidize rising private insurance premiums for policies that cover fewer and fewer services. The result is a flow of patient and public dollars into the coffers of private insurance corporations with declining return in terms of health care. This trend is not sustainable.

The alternative scenario of a national improved Medicare for All will save lives and save money. National improved Medicare for All will place our nation on the path of becoming one of the best health systems in the world – something of which we can all be proud. This commission has the ability to recommend creating a financially sustainable universal health system. I urge the members of this commission to recommend addressing the deficit through adopting this most popular approach: national improved Medicare for All. Don't cut Medicare. Protect it, improve it and expand it to cover everyone.

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*attachments

Light, D. W., and J. Lexchin. 2004. Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet. *The American Journal of Bioethics* 4(1):W3-W6.

# *Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet*

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This documented fact sheet provides evidence that all drug research by large firms, net of taxpayers' subsidies, is paid for out of domestic sales in each country, with profits to spare. Prices can be lower without jeopardizing basic research for new drugs. More exposure to global price competition would encourage more innovative research and less of the derivative me-too research that now dominates.

In the U.S., the FDA Commissioner, Mark McClellan, and the drug industry are responding to pressures for lower costs by mounting a large campaign to pressure all other affluent countries to raise their prices to U.S. levels. They claim that lower prices do not pay for drug research costs, but we provide evidence that this is untrue. Ultimately, however, such nationalistic arguments are based on regarding basic research and new discoveries, which can happen anywhere, and the cost of trials, which are carried out in the countries deemed most commercially advantageous, as part of national companies and national accounts, when in fact they are part of a global economy for pharmaceutical products.

**FDA Myths**

1. FDA Commissioner, Mark McClellan, holds that other affluent countries like Canada and the UK set their prices for patented drugs so low that they do not pay for research and development (R&D) (McClellan 2003). We can find no evidence to support that claim.

> On the contrary, audited financial reports of major drug firms in the UK, show that all research costs are paid, with substantial profits left over, based solely on domestic sales at British prices (Pharmaceutical Price Regulation Scheme 2002). Likewise, 79 research drug companies in Canada submitted reports showing their R&D expenditures have risen more than 50% since 1995, all paid for by domestic sales at Canadian prices (Patented Medicine Prices Review Board 2002). Sales to the U.S. and elsewhere are in addition to the positive, domestic balance sheets.

2. FDA Commissioner McClellan says that European or Canadian prices are "slowing the process of drug development worldwide" (McClellan 2003). There is no known verifiable evidence to support this claim. In fact, drug research has been increasing steadily in Europe as well as in the U.S., with some countries having a more rapid increase than the U.S. (Patented Medicine Prices Review Board 2002).

3. FDA Commissioner McClellan says that "price controls discourage the R&D needed to develop new products" (McClellan 2003). But there is no known verifiable evidence to support this claim.

> R&D expenditures have been growing rapidly, though it is becoming more and more difficult to discover breakthrough drugs on targets not already hit (Harris 2003). The truth kept from Americans is that first-line treatment for 96% of all medical problems requires only 320 drugs (Laing et al. 2003). In wealthy countries, more drugs might be appropriate to treat people who do not respond to first-line agents.

4. FDA Commissioner McClellan charges that efforts to negotiate lower prices for patented drugs by other countries (and by major employers, unions and governors in the U.S.) are "no different than violating the patent directly" to make cheap copies (McClellan 2003). This charge echoes the drug industry and implies that large buyers seeking better value should be considered a criminal act.

5. FDA Commissioner McClellan paints a picture of other wealthy countries driving down their prices to marginal costs, but the widening gap between prices for patented drugs in the U.S. and other countries is due to drug companies raising U.S. prices, not other countries lowering theirs (Sager and Socolar 2003; Families USA 2003).

6. The "free-rider" problem that McClellan emphasizes can be solved by U.S. prices coming down to European levels, where they will cover all R&D costs, plus profits that are higher than those in most industries.

7. Drug company profits, after all R&D costs, have long been more than double the profits of Fortune 500 corporations. In recent years they have jumped to triple and even quadruple the profits of other major companies (National Institute for Health Care Management 2000). The global firms spend two and a half to three times more for marketing and administration than for research (Families USA 2001).

8. Americans pay for more R&D than any other country because the United States accounts for more sales than any other country. But while the U.S. accounts for 51% of world sales, it took 58% of global R&D expenditures invested in the US to discover only 43% of the more important new drugs (NCEs) (European Federation of Pharmaceutical Industries and Associations 2003). This means that other countries are helping to pay for the large, inefficient U.S. R&D enterprise, the opposite of what the editors of *Business Week* claimed (Business Week editors 2003). William Safire's claim of a "foreign rip-off" as Americans pay for the world's R&D is contradicted by the

facts above (Safire 2003).

**Research is misdirected by the industry, against patients' interests**

9. Most drug innovation provides little or no therapeutic advantage over existing

> Independent review panels plus a major industry review conclude that only 10 - 15 % of "new" drugs provide a significant therapeutic breakthrough over existing drugs and involve a new chemical or molecule (Barral 1996; Prescrire International 2003; National Institute for Health Care Management Research and Education Foundation 2002). Other industry-sponsored figures are much higher but not reliable.

10. The FDA approves drugs that are better than nothing (placebo) but does not test them against the best existing drugs for the same problem. Most research is for "new" drugs to treat problems already treated by other drugs.

11. About 18% of the drug industry's research budget goes to basic research for breakthrough drugs. About 82% goes to derivative innovations on existing drugs and to testing.

> The long-standing survey of basic research by the National Science Foundation estimates that basic research has increased to 18% of the total research and development (R&D) budget for the pharmaceutical industry. It used to be less (National Science Foundation 2003). Industry-sponsored figures based on secret unverifiable data are much higher but not reliable (DiMasi, Hansen, and Grabowski 2003). The 85-90% of "new" drugs that have little therapeutic gain reflects equal protection from competition for much less investment and risk.

12. Congress has repeatedly extended patent protection for drugs beyond what other industries enjoy, despite much higher profits year in and year out. Government protection from normal competition is now more than 50% greater for the drug industry than a decade ago (National Institute for Health Care Management 2000). These incentives reward research into derivative large markets, rather than to finding effective treatments for diseases that have none.

13. These facts constitute the Blockbuster Syndrome: the lure of monopoly pricing and windfall profits for years spurs the relentless pursuit for drugs that might sell more than $1 billion a year, regardless of therapeutic need or benefit. Research projects for the disorders of affluent nations proliferate, as do clinical trials. Doctors are paid like bounty hunters to recruit patients for thousands of dollars each. Most patients get the misimpression that the experimental drug will be better than existing ones (Wolpe 2003). The corruption of professional judgment, ethics and even medical science follow (Williams 2003; Wazana 2000; Barnett 2003; Lexchin, Bero, Djulbegovic et al. 2003; Bekelman, Mphil, and Gross 2003; Villanueva, Peiro, Librero et al. 2003; Fletcher 2003).

**Drug research costs much less than claimed**

14. Drug companies claim to spend 17% of domestic sales on R&D, but more objective data reports they spend only 10% (National Science Foundation 2003). Thus, only 1.8% of sales goes to research for breakthrough new drugs (18% x 10%) (Love 2003).

15. Taxpayers pay for most research costs, and many clinical trials as well.

> In 2000, for example, industry spent 18% of its $13 billion for R&D on basic research, or $2.3 billion in gross costs (National Science Foundation 2003). All of that money was subsidized by taxpayers through deductions and tax credits. Taxpayers also paid for all $18 billion in NIH funds, as well as for R&D funds in the Department of Defense and other public budgets. Most of that money went for basic research to discover breakthrough drugs, and public money also supports more than 5000 clinical trials (Bassand, Martin, Ryden et al. 2002). Taxpayer contributions are similar in more recent years, only larger.

16. The average amount of research funds the drug industry needs to recover appears to be much less than the industry's figure of $800 million per new drug approved (NDA).

> The $800 million figure is based on the small unrepresentative subsample of all new drugs. It excludes the majority of "new" drugs that are extensions or new administrations of existing drugs, as well as all drugs developed by NIH, universities, foundations, foreign teams, or others that have been licensed in or bought. Variations on existing drugs probably cost much less because so much of the work has already been done and trials are simpler.
>
> About half of the $800 million figure consists of "opportunity costs", the money that would have been made if the R&D funds had been invested in equities, in effect a presumed profit built in and compounded every year and then called a "cost." Drug companies then expect to make a profit on this compounded profit, as well as on their actual costs. Minus the built-in profits, R&D costs would average about $108 million 93% of the time and $400 million 7% of the time.
>
> The $800 million estimate also does not include taxpayers' subsidies via deductions and credits and untaxed profits (DiMasi, Hansen, and Grabowski 2003; DiMasi, Hansen, Grabowski et al. 1991). Net R&D costs are then still lower.
>
> Contrary to some press reports from the industry, screening for new compounds is becoming faster and more efficient and the time from initial testing to approval has shortened substantially (Kaitin and Healy 2000). The large size of trials seems more due to signing up specialists to lock in substantial market share. Advertising firms are now running clinical trials (Bassand, Martin, Ryden et al. 2002; Peterson 2002; Moyers 2002).

17. Because clinical trials have become a high-profit subindustry, trial "costs" appear to be much more than is nec-

essary.

> An international team of experts estimates that clinical trials could be done for about $500 per patient rather than $10,000 per patient, a 95% reduction (Bassand, Martin, Ryden et al. 2002). The most detailed empirical study of trial costs also concludes that costs can be much less than reported (The Global Alliance for TB Drug Development 2001).

**U.S. drug prices very high**

18. Americans seem unaware how much more they are paying for drugs than other countries, in the name of the "free market" where prices are controlled by corporations. So-called "price controls" abroad are negotiated wholesale prices. Corporate price controls in the U.S. are un-negotiated monopoly prices, which then large buyers negotiate down.

> According to a detailed analysis, American employers and health plans pay at wholesale 2.5-3.5 times the prices in Australia and other countries with comparable prices for patented drugs (Productivity Commission of Australia 2001). There is no evidence that these prices do not cover research costs. U.S. generic prices shadow patent drug prices and are also 2.5-3.5 times more.

19. High American prices are essentially monopoly rents charged to employers in every other industry. They shift profits from other industries to the drug industry.

20. If American prices were cut in half, research budgets would not have to suffer unless executives decided to cut them in favor of marketing, luxurious managerial allowances or high profits. They probably would not, because R&D gets such favorable tax treatment compared to other expenses. Lower prices would save other Fortune 500 companies billions in drug benefit costs, and drug company profits could come into line with the profits of the companies who pay for their drugs.

**Realign incentives to reward true innovation**

21. Current incentives strongly reward derivative innovation. We get what we reward.

22. Because the U.S. is by far the biggest spender, it has by far the most R&D and new drugs. Four other industrialized countries, however, devote more of their GDP to R&D for new drugs than the U.S. (Patented Medicine Prices Review Board 2002).

23. Officials of drug companies commonly claim that nearly all new drugs are discovered in the U.S. However, the industry's own studies (and others) show that over the past quarter century, the U.S. has accounted for less than or about the same as its proportionate share of international new drugs, not more and certainly not nearly all (Barral 1996; European Federation of Pharmaceutical Industries and Associations 2000). Until 2002, even the U.S. pharmaceutical industry was investing an increasing percent of its R&D budget in highly productive research teams abroad (Pharmaceutical Research and Manufacturers of America 2002).

24. Americans are getting less innovation and paying a lot more. Competing countries profit from these American self-delusions by covering their R&D and keeping their own drug prices reasonable, while leaving drug companies to make bonanza profits from the monopoly American market.

25. Price competition has been the greatest spur to innovation for over 200 years. Price protections reward derivative and me-too innovation as well as excessive costs and a focus on blockbuster marketing. If we want lower prices and more breakthrough innovations, we need to change the incentives to reward those goals (Baker and Chatani 2002).

**Authors' Disclosure Statement**

In 1996, JL received funding from Sandoz (now part of Novartis) for travel and accommodation to attend a meeting in Basle, Switzerland with Sandoz executives to discuss marketing practices.

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# Evidence Based Talking Points

**Talking Point 1: Administrative costs consume 31 percent of health spending, most of it unnecessary.**

"Costs of Health Care Administration in the U.S. and Canada." Woolhandler, S., Campbell, T., & Himmelstein, D.U. (2003), N Engl J Med, 349, 768-775.

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**Talking Point 2: Nearly two-thirds of all bankruptcies are caused by medical bills. Three-fourths of those bankrupted had health insurance at the time they got sick or injured.**

"Medical Bankruptcy in the United States, 2007: Results of a National Study." Himmelstein, D.U., Thorne, D., Warren, E., Woolhandler, S. (2009), Am J Med, 122, 741-746.

"Medical Bankruptcy Fact Sheet." Himmelstein, D.U., Thorne, D., Warren, E., Woolhandler, S. (2009).

"Medical Bankruptcy Q&A." Himmelstein, D.U., Thorne, D., Warren, E., Woolhandler, S. (2009).

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**Talking Point 3: Taxes already pay for more than 60 percent of US health spending Americans pay the highest health care taxes in the world. We pay for national health insurance, but don't get it.**

"Paying for National Health Insurance - And Not Getting It." Woolhandler, S. & Himmelstein, D.U. (2002), Health Affairs 21(4), 88-98.

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**Talking Point 4: Despite spending far less per capita for health care, Canadians are healthier and have better measures of access to health care than Americans. Taiwan's new single payer system (adopted in 1996) has improved access to care (before its adoption, 40 percent of the population was uninsured), controlled costs, and is model of efficiency. Despite having the highest per capita health spending in the world, the U.S. health system ranks very poorly in international comparisons of quality, outcomes, patient satisfaction, and other measures.**

"Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey." Lasser, K., Himmelstein, D.U., & Woolhandler, S. (2006), Am J Public Health, 96, 1300-1307.

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"Learning from Taiwan: Experience with Universal Health Insurance." Davis, K. & Huang, A.T. (2008), Ann Intern Med, 148, 313-314.

"It's The Prices, Stupid: Why The United States is So Different From Other Countries." Anderson, G., Reinhardt, U.E., Hussey, P.S., & Petrosyan, V. (2003), Health Affairs, 22(3), 89-105.

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**Talking Point 5: Business pays less than 20 percent of our nation's health bill. It is a misnomer that our health system is "privately financed." 60 percent is funded by taxes and the remaining 20 percent is out-of-pocket payments.**

"A Reappraisal of Private Employers' Role in Providing Health Insurance." Carrasquillo, O., Himmelstein, D.U., Woolhandler, S., & Bor, D.H. (1999), N Engl J Med, 340, 109-114.

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**Talking Point 6: For-profit, investor-owned hospitals, HMOs, and nursing homes have higher costs and score lower on most measures of quality than their non-profit counterparts. For-profit hospitals have higher death rates.**

"The high costs of for-profit care." Himmelstein, D. & Woolhandler, S. (2004), Can Med Assoc J, 170, 1814-1815.

"Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis." Devereaux, P.J., et. al. (2004), Can Med Assoc J, 170, 1817-1824.

"A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals." Devereaux, P.J., et. al. (2002), Can Med Assoc J, 166, 1399-1406.

"Costs of Care and Administration at For-Profit and Other Hospitals in the United States." Woolhandler, S., & Himmelstein, D.U. (1997), N Engl J Med, 336, 769-775.

"Quality of Care in Investor-Owned vs. Not-for-Profit HMOs." Himmelstein, D.U., Woolhandler, S., Hellander, I., & Wolfe, S.M. (1999), J Am Med Assoc, 282, 159-163.

"Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" Harrington, C., Woolhandler, S., Mullan, J., Carrillo, H., & Himmelstein, D.U. (2001), Am J Public Health, 91, 1452-1455.

**Talking Point 7: Immigrants and emergency department visits by the uninsured are not the cause of high and rising health care costs.**

"Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis." Mohanty, S., et. al. (2005), Am J Public Health, 95, 1431-1438.

"US Emergency Department Costs: No Emergency." Tyrance, P.H., Himmelstein, D.U., & Woolhandler, S. (1996), Am J Public Health, 95, 1527-1531.

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**Talking Point 8: The uninsured do not receive all the medical care they need: one-third of uninsured adults have chronic illness and don't receive needed care. Those most in need of preventive services are least likely to receive them.**

"A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults." Wilper, A., et. al. (2008), Arch Intern Med, 149, 170 - 176.

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**Talking Point 9: The U.S. could save enough on administrative costs (almost $400 billion in 2009) with a single-payer system to cover the uninsured.**

"Costs of Health Care Administration in the U.S. and Canada." Woolhandler, S., Campbell, T., & Himmelstein, D.U. (2003), N Engl J Med, 349, 768-775.

"Proposal of the Physicians' Working Group for Single-Payer National Health Insurance." Woolhandler, S., Himmelstein, D.U., Angell, M., & Young, Q.D. (2003), J Am Med Assoc 290, 798-805.

"Summary of Fiscal Studies: How Much would Single Payer Cost?"

"Canadian Health Insurance: Lessons for the Unites States." U.S. General Accounting Office. (1991), GAO/HRD-91-90 Canadian Health Insurance.

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**Talking Point 10: Competition among investor-owned, for-profit entities has raised costs reduced quality in the U.S.**

"Competition in a publicly funded healthcare system." Woolhandler, S. & Himmelstein, D.U. (2007), Brit Med J, 335, 1126-1129.

"Market-Based Failure – A Second Opinion on U.S. Health Care Costs." Kuttner, R. (2008), N Engl J Med, 358, 549-551.

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**Talking Point 11: The Canadian single payer healthcare system produces better health outcomes with substantially lower administrative costs than the United States.**

"A systematic review of studies comparing health outcomes in Canada and the United States." Guyatt G.H., et al. (2007), Open Medicine, 1, E27-36.

"Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey." Lasser, K., Himmelstein, D.U., & Woolhandler, S. (2006), Am J Public Health, 96, 1300-1307.

"Who administers? Who cares? Medical Administrative and Clinical Employment in the United States and Canada." Himmelstein, D., Lewontin, J.P., & Woolhandler, S. (1996), Am J Public Health, 86,172-178.

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"Mythbusters: The cost of dying is an increasing strain on the healthcare system." Canadian Health Services Research Foundation. (2003).

"Mythbusters: User fees would stop waste and ensure better use of the healthcare system." Canadian Health Services Research Foundation. (2001).

"Privatizing health care is not the answer: lessons from the United States." Angell, M. (2008), Can Med Assoc J, 179, 916-919.

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**Talking Point 12: Computerized medical records, chronic disease management, and malpractice reform do not save money. The only way to slash administrative over-head and improve quality is with a single payer system.**

"Hospital computing and the costs and quality of care: a national study." Himmelstein, D.U., Wright, A & Woolhandler, S. (2009), Am J Med, 2009 Nov 16.

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**Talking Point 13: Alternative proposals for "universal coverage" (e.g. based on the Federal Employees Health Benefits Program, the old "Clinton health plan" or the recent reform in Massachusetts) do not work. State health reforms over the past two decades have failed to reduce the number of uninsured.**

"State Health Reform Flatlines." Woolhandler, S., Day, B., & Himmelstein, D.U. (2008), Int J Health Serv, 38, 585-592.

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**Talking Point 14: Drug companies spend more on marketing (31 percent) and profits (20 percent) than on R & D (13 percent). Lower drug prices would not jeopardize drug innovation, much of which is, in fact, publicly-funded.**

"Extraordinary Claims Require Extraordinary Evidence." Light, D.W. & Warburton, R.N. (2005), J Health Econ, 24, 1030-1033.

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**Talking Point 15: Co-pays and deductibles are not necessary to control costs and reduce necessary care as much as unnecessary care. It is a myth that patient overuse will bankrupt any system without cost-sharing and that the demand for healthcare is "infinite".**

"Cost Sharing in Health Insurance – A Reexamination." Rasell, M.E. (1995), N Engl J Med, 332, 1164-1168.

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**Talking Point 16: Universal coverage cannot be achieved with U.S.-style investor-owned private insurance companies. Every other industrialized, capitalist country has some form of non-profit national health care. For-profit, private insurance (mostly "gap" coverage) accounts for less than 5 percent of health expenditures in Europe.**

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“Private health insurance and access to health care in the European Union.” Thompson, S. & Mossialos, E. (2004), Euro Observer, 6(1).

“Health Care Systems - Four Basic Models.” Reid, T.R.

“Health care reform must start with a plan to simplify.” McCanne, D. (2008), Quote of the Day, Sept. 18.

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**Talking Point 17: A majority of physicians (59 percent), and an even higher proportion of Americans (two-thirds) support single payer national health insurance or “Medicare for all.” Polling indicates that people are also willing to pay “higher taxes” for guaranteed coverage and that even the term “socialized medicine” has lost its negative connotations.**

“Support for National Health Insurance among U.S. Physicians: 5 Years Later.” Carroll, A.E. & Ackerman, R.T. (2008), Ann Intern Med, 148, 566.

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